STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005085	A. BUILDING: _____ B. WING _____	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW LAGRANGE HOSPITAL	207 N TOWNLINE RD LAGRANGE, IN 46761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00136605 Unsubstantiated; lack of sufficient evidence. Survey Date: 10-23-13 Facility Number: 005085 Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor Parkview Lagrange Hospital is in compliance with 410 IAC 15-1.5-2, Infection control, and 410 IAC 15-1.5-8, Physical plant, maintenance, and environmental services, Indiana Hospital Licensure Rules. QA: claughlin 11/26/13	S 000		